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NOT TO BE PUBLISHED

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

(Sacramento)

PAUL JEFFREY DAVIS, Plaintiff and Appellant, v. BOARD OF CHIROPRACTIC EXAMINERS, Defendant and Respondent.	C059588 (Super. Ct. No. 07CS00697)

The Board of Chiropractic Examiners (Board) spent over $72,000 in its disciplinary proceedings against Dr. Paul Davis, a 20-year veteran chiropractor in both neurology and orthopedics, for his treatment and billing of a single patient who suffered two industrial accidents at two places of employment with different insurers. Neither the patient nor the insurers accused Dr. Davis of unprofessional conduct. Dr. Davis had never had a workers' compensation patient with claims against two insurers simultaneously, and he had never had a complaint filed against him by a patient or an insurer. The Board revoked his license but stayed the revocation, imposed a

three-year term of probation, and directed him to reimburse the Board for costs in the amount of $72,242.80.

Dr. Davis appeals the denial of his petition for a writ of administrative mandamus seeking to overturn the Board's findings. He frames his two appellate issues as questions of law, not fact. He contends that California Code of Regulations, title 16, section 318 (hereafter Board Regulation section 318) provides chiropractors with a 30-day safe harbor period during which they can correct billing errors and that he fell within the safe harbor by sending corrections to the insurers within 30 days of the conclusion of an in-house audit. Secondly, he asserts that "excessive treatment" is void for vagueness.

While the facts present an unusual context for a finding of professional misconduct, an appellate court is not at liberty to draw its own inferences from the facts. Rather, we are constrained to answer the only two legal questions presented. We conclude Board Regulation section 318 is not a safe harbor provision exonerating Dr. Davis for his negligent acts, and the prohibition for "excessive treatment" is not unconstitutionally vague. Thus, as a matter of law, we are compelled to affirm the denial of the writ of mandamus.

FACTS

The Patient

J.T. was a needy patient. In 1996 he hurt his wrist at work and sought treatment from Dr. Davis. That industrial injury is not at issue in this case.

In November 1999 J.T., then in his early 20's, slipped and fell at HoneyBaked Ham during a busy shift just before Thanksgiving. He filed a workers' compensation claim that was handled by Highlands Insurance Company. On January 3, 2000, he sought treatment from Dr. Davis for the back injury he sustained in this slip and fall. J.T. asked so many questions that his initial interview extended over part of three days. He sought over 160 treatments for his back injury. Finally, approximately two years later he got too busy to continue his treatments when he returned to school.

In March 2000 he sustained his third industrial injury. While working at California State University at Fullerton, he tripped and fell down some stairs, spraining his ankle and exacerbating his back injury. He filed his third workers' compensation claim, which was handled by Superior National Insurance Company. Again, he sought over 100 treatments from Dr. Davis over the course of two years. He testified that the treatments alleviated his symptoms and he believed that Dr. Davis cared about him. Dr. Davis continued to patiently answer his voluminous questions during the entire time J.T. remained under his care.

Billing

J.T. was the only patient during Dr. Davis's 20-year practice to be treated simultaneously for two industrial injuries at two different job sites covered by two different insurers. The complexity of the billing led to the unfortunate

mistakes an inexperienced billing clerk made in Dr. Davis's office.

Dr. Davis's wife assumed responsibility for billing. She hired and trained staff. Hoping to provide a work opportunity for a single mother with five children, she hired Norma Rosales from a welfare-to-work program. As far as Dr. Davis and his wife were aware, Ms. Rosales billed competently. They never received any complaints or notification from any insurer that she had erred on a bill. During the time that J.T. sought treatment for his back and ankle injuries, Dr. Davis's wife had a high-risk pregnancy and gave birth to a son with special medical needs. She therefore had reduced her workload and had delegated more of the billing during this time to Ms. Rosales.

On May 22, 2002, Dr. Davis was deposed in one of J.T.'s workers' compensation cases. Clifford Sweet, an attorney representing the insurer, accused him of billing irregularities. Although Dr. Davis held Mr. Sweet in very low regard, he instructed his wife to audit J.T.'s bills.

The audit was completed on July 30, 2002. It revealed there had been approximately 114 billing errors, some in favor of the respective insurer and some in favor of Dr. Davis. Dr. Davis's wife sent the corrected billings to Highlands Insurance on August 13, 2002, and to Superior National Insurance on August 21, 2002.

Dr. Davis and his wife both testified that he had very little to do with the billing practices in his chiropractic

offices. He did not know most of the codes they were required to use. He relied on his staff to bill for his services.

Doctor Michael Stahl

Clifford Sweet retained Michael Stahl, D.C., in J.T.'s underlying workers' compensation case. Unlike Dr. Davis and his expert, Michael Martello, D.C., Dr. Stahl is not a chiropractic orthopedist or a qualified medical examiner (QME). Yet Sweet represented to the Board that Dr. Stahl performed a QME evaluation. Dr. Stahl received a copy of Sweet's representation, but he did not correct it to reflect that he was not a QME. Only 15 percent of his practice involved patients seeking treatment for workers' compensation injuries, a substantial decline since the workers' compensation system was reformed in 2005.

Dr. Stahl testified that it is common in the industry to have billing staff. He accused Dr. Davis of double-billing and "up-coding" (charging for more services than were provided). Dr. Davis himself admitted his staff had made the mistakes but denied that he knew about them or intended to defraud the insurers.

Doctor Phillip Rake

Board expert Phillip Rake, D.C., saw no justification in Dr. Davis's records for the amount of treatment J.T. received. He opined the treatment was excessive because there was no medical necessity to support it and because over time it became "entirely palliative." Excessive treatment, according to Dr. Rake, violated the standard of practice, a standard that did

not vary when chiropractors treated workers' compensation patients.

Doctor Paul Davis

As a young boy, Dr. Davis yearned to become a chiropractor because his mother suffered acute back pain and he hoped to relieve his patients' pain. He became a diplomate in both chiropractic neurology and chiropractic orthopedics, a distinction earned by only a few chiropractors nationwide. Until the filing of the instant accusation, the record reflects that Dr. Davis enjoyed an unblemished 20-year chiropractic practice, devoting long hours to treating his patients. Neither patients nor insurers registered any complaints.

Nevertheless, he admitted he delegated billing responsibilities to others. While he expected all of his staff to maintain high standards, he did not understand the nuances of billing, did not assure their accuracy, and did not realize that the bills to the two insurers in J.T.'s case were fraught with errors.

Dr. Davis explained the complexities of J.T.'s case, both in terms of treatment and of billing. J.T. was a high-maintenance patient requiring an unusual amount of time and patience. He came to his appointments with lists of questions. Dr. Davis attempted to address all of his concerns. Moreover, it was difficult to segregate the treatment he provided for one injury from the other, particularly because J.T. aggravated the back injury when he sprained his ankle. Finally, once J.T.'s condition became permanent and stationary and he was entitled to

future medical services, Dr. Davis believed that J.T. was entitled to palliative treatment to minimize the discomfort of occasional flare-ups and to allow him to continue his daily activities. Dr. Davis does not dispute he treated J.T.'s back over 160 times and his ankle over 100 times.

Doctor Michael Martello

Michael Martello, D.C., at the time of the administrative hearing, had been practicing as a chiropractor for 23 years. During that time, he amassed an impressive array of certifications, positions, and qualifications, including certification regarding disability evaluation in the State of California by the International Chiropractors Association of California; teaching continuing education programs in the State of California, primarily related to the treatment of industrial injuries; serving on testing panels for the Industrial Medical Council, and panels for the development of guidelines; membership in or on the American Board of Chiropractic Orthopedists, the California Society of Industrial Medicine and Surgery, and the board of trustees for the Western States Chiropractic College; serving as an examination commissioner for the American Board of Chiropractic Orthopedists and as a fellow of the International College of Chiropractors; recognition as chiropractic orthopedist of the year for the American Chiropractic College of Orthopedists; serving as chairman of the examining board for the American Chiropractic Academy of Neurology; diplomate of the American Board of Chiropractic Orthopedists; participation on the ethics committee for the

California Chiropractic Association, the test development panel for QME's, and the task force on consumer complaints and unfair practices for the Department of Insurance; serving as a QME for the State of California; and, most significantly, serving as the vice-chairman of the California Board of Chiropractic Examiners.

Dr. Martello reviewed J.T.'s entire file. As an expert on treatment, he testified that J.T. had sustained a multiple-level spinal injury. Simply put, this was not a simple back injury. Indeed, according to Dr. Martello, J.T. required extensive treatment to obtain permanent and stationary status. He would never fully recover from the back injury. "Because every patient is different, every injury is different, and every patient responds to treatment differently," Dr. Martello opined that there was not a community standard for the number of treatments required for an injury like J.T.'s. Similarly, he could not say how many treatments it would take to treat the type of ankle sprain J.T. sustained because each patient's response to such an injury would be unique. In his view, there was no community standard for how many treatments an ankle injury would require.

Dr. Martello testified the Board had not codified any standard of care for the treatment of chiropractic patients in California. He distinguished the treatment guidelines available from the Industrial Medical Council from a standard of care, opining that the guidelines did not constitute a standard.

Despite the absence of a standard of care, Dr. Martello believed that spinal manipulation, electromusculostimulation,

myofascia release, ultrasound, intersegmental traction, and massage were appropriate and necessary treatments for J.T.'s back injury. Dr. Martello stated, "It is a wonderful treatment plan. In fact, if I hurt my back that is the treatment plan I would want applied to me." Ultrasound, myofascia release, and massage were also appropriate and necessary treatments for J.T.'s ankle injury. They were "good for both an acute injury as well as a chronic injury." These treatments, according to Dr. Martello, should continue to be applied after the injuries become permanent and stationary to relieve pain, increase mobility, and reduce swelling. He testified that there could be a difference of opinion between chiropractors as to what treatment plans are appropriate but emphasized that the treating chiropractor is in the best position to evaluate the patient, the healing process, and the response to the prescribed treatment.

Dr. Martello, like Dr. Rake, testified that chiropractic treatment must be justified by medical necessity. According to Dr. Martello, "[m]edical necessity is determined by a number of factors, including the patient's subjective complaints, most commonly pain or some other symptom, objective examination findings, a consideration of past treatment, and the patient's response to past care and whether there is a reasonable chance that the treatment will cure or relieve the effects of the injury." The failure to record subjective complaints did not negate the fact that the treatment provided was medically necessary.

Administrative Findings

Following a 10-day hearing, the administrative law judge (ALJ) made findings later adopted by the Board. As to billing, the ALJ found: "[I]n J.T.'s case, either the [health insurance claims forms (HCFA)] were not forwarded to respondent for his review, or they were forwarded to respondent and he failed to properly review the forms to ensure billing accuracy. In any event, it does not appear that respondent had the requisite knowledge to determine if the CPT codes [for] services/ treatments rendered were properly reflected on the HCFA forms. Respondent testified that he is 'not familiar' with the 'coding,' and coding is so complex that it 'is a career in and of itself.' Respondent relied on 'others' to 'keep up with CPT and OMFS codes.' Respondent 'entrusted' his wife to ensure billing accuracy in 'that area.' Although respondent claimed that he reviewed the bills once the HCFA forms were completed, he 'does not know the codes.' Respondent's wife testified that respondent 'has nothing to do with the billing.' Respondent's failure to ensure the accuracy of his billings constitutes negligent acts and, in the aggregate, gross negligence."

The ALJ further reported on the number of errors in J.T.'s bills. "Numerous billing errors occurred in the present instance with respect to J.T. From January 2000 through October 2002, there were approximately 114 billing errors. The errors included double billing (both insurance companies billed for the same treatment), billing of incorrect CPT codes, billing the incorrect carrier, and billing for services not rendered on

a particular date of service. [¶] . . . Respondent was not aware of the billing errors due to his gross negligence and repeated negligence by not adequately supervising his billing procedures and billing staff, and by not reviewing the HCFA forms for accuracy prior to the forms being sent to carriers for payment."

As to J.T.'s treatment, the ALJ found: "The evidence and the reasonable inferences drawn from the evidence indicate that, in the present instance, after setting up the treatment plans for J.T. on the cover of J.T.'s chart, respondent delegated J.T.'s treatment and care to his (respondent's) chiropractic assistants. [Fn. omitted.] After the initial course of therapy, J.T. began scheduling appointments whenever he felt he needed them. J.T. would make his appointments, arrive at respondent's facility, be treated by one of respondent's employees/chiropractic assistants with massage, ultrasound, electrical stimulation, RICE, etc. These therapies made J.T. feel better, so he continued the treatments even though there was no medical necessity for the nature and number of the continued 'treatments.' Consequently, respondent was repeatedly negligent and acted in a grossly negligent manner in his treatment of J.T. by allowing J.T. to become dependent, by providing treatments that were not medically necessary and by fostering chronicity."

The ALJ found no cause for discipline for any acts of moral turpitude, dishonesty, corruption, fraud, or misrepresentation, or for knowingly presenting false insurance claims. He did,

however, conclude there was cause for discipline for his commission of acts of gross negligence in billing J.T.'s insurers and for providing J.T. excessive treatment, both of which constitute unprofessional conduct.

Administrative Mandamus

Apparently frustrated by the anemic record provided by Dr. Davis, particularly the number of missing exhibits, the trial court concluded that he failed to meet his burden of establishing that the findings are not supported by the weight of the evidence. He does not challenge this ruling or the court's evaluative analysis of the weight of the expert evidence.

Dr. Davis instead challenges two legal issues. The trial court found that the inclusion in California Code of Regulations, title 16, section 317, subsection (d) (hereafter Board Regulation section 317) of "'[t]he administration of treatment or the use of diagnostic procedures which are clearly excessive as determined by the customary practice and standards of the local community of licensees'" as unprofessional conduct is "not unconstitutionally vague, and that written, formally adopted guidelines are not necessary."

As to the second issue, the court also lamented Dr. Davis's failure to provide a copy of the deposition wherein it was alleged that he was given notification of the J.T. billing errors. The court stated it would not find an abuse of the Board's discretion on the record provided. The court did conclude, however, that it was not persuaded the "30-day period

began on July 30, 2002, when his office administrator, his wife, concluded the review of billings which he had requested her to perform." Even if Dr. Davis had corrected the billings within 30 days, the court found "the evidence supports the finding that he was negligent in regard to billings. Petitioner is responsible for the actions of his staff, which he did not properly supervise. [Board Regulation] Section 318 does not provide a 'safe haven' against claims of negligence."

Dr. Davis appeals the denial of his petition for a writ of administrative mandamus.

DISCUSSION

I

Billing Errors

Board Regulation section 318, subdivision (b) provides: "Accountable Billings. Each licensed chiropractor is required to ensure accurate billing of his or her chiropractic services whether or not such chiropractor is an employee of any business entity, whether corporate or individual, and whether or not billing for such services is accomplished by an individual or business entity other than the licensee. In the event an error occurs which results in an overbilling, the licensee must promptly make reimbursement of the overbilling whether or not the licensee is in any way compensated for such reimbursement by his employer, agent or any other individual or business entity responsible for such error. Failure by the licensee, within 30 days after discovery or notification of an error which

resulted in an overbilling, to make full reimbursement constitutes unprofessional conduct."

Dr. Davis contends that the final sentence of Board Regulation section 318, subdivision (b) provides a safe harbor for chiropractors; that is, a chiropractor remains immune to charges of professional misconduct provided he or she corrects the errors and makes full reimbursement during the 30-day grace period. He further argues that the Board and the trial court erred as a matter of law by construing "discovery or notification" to mean mere "notice." In Dr. Davis's view, he was wrongfully denied the benefit of section 318's safe harbor based on the erroneous finding that he was notified of the errors at the deposition on May 22, 2002, rather than at the completion of his in-house audit on July 30, 2002. We need not construe the meaning of "discovery or notification" because we conclude section 318, subdivision (b) does not provide a 30-day safe harbor for negligence.

Other statutes and regulations provide a general framework relevant to our analysis. Pursuant to section 10, subdivision (b) of the Chiropractic Act (3A, pt. 1, West's Ann. Bus. & Prof. Code (2003 ed.) pp. 442-443), the Board may take disciplinary action based on any violation of the rules and regulations adopted by the Board in accordance with the Chiropractic Act or for any cause specified in the act. Board regulation section 317, subdivisions (a) and (b) state that unprofessional conduct includes, but is not limited to, gross negligence and repeated negligent acts.

We agree with the Attorney General that under this framework the first sentence of Board Regulation section 318, subdivision (b) is dispositive. The first sentence imposes a duty on chiropractors to "ensure accurate billing of his or her chiropractic services." The Board found Dr. Davis guilty of gross negligence in billing. Thus, his billing constituted unprofessional conduct under Board Regulation section 317, and the Board was justified in taking disciplinary action based on Dr. Davis's violation of the rules and regulations set forth in section 318, subdivision (b). Whether the insurers brought the billing errors to his attention is irrelevant to his duty to prevent them from occurring in the first place.

Yet Dr. Davis insists the final sentence provides a 30-day safe harbor during which he could evade responsibility for his negligence by correcting the errors and making full reimbursement. He cites no authority to support such an escape valve. We agree with the trial court that "[s]ection 318 does not provide a 'safe haven' against claims of negligence."

First, we turn to the language of the regulation, written as it is in the negative rather than the positive. Certainly, the regulation does not state that chiropractors have 30 days to correct errors; rather, it states the reverse—that the failure to correct errors within 30 days constitutes unprofessional conduct. Thus, if the Board has evidence the chiropractor either discovered or was notified of an error and did nothing to correct it within 30 days, there is cause for disciplinary action for unprofessional conduct. In short, the last sentence

speaks to a failure to act once an error is discovered; it does not exonerate a chiropractor for gross negligence or repeated acts of negligence.

Second, we reject the notion that the Board intended to give chiropractors a 30-day free pass for negligence when the express intent of the section is to impose a stringent duty on them to ensure accurate billing. Board Regulation section 318, subdivision (b) imposes such a duty on chiropractors "whether or not billing for such services is accomplished by an individual or business entity other than the licensee." Thus, the scope of responsibility is expansive. A chiropractor's professional obligation to ensure accurate billing extends to any form of business and any form of billing. We will not presume that the Board intended to create such a gaping loophole for negligence at the same time it found a need to impose a kind of strict liability on chiropractors to make sure all billing for chiropractic services is accurate.

In reply, Dr. Davis contends he was not disciplined for errors in his billings, but because he was on notice of those errors. Not so. The Board found cause for discipline because of Dr. Davis's "failure to ensure accurate billing *and* his failure to correct the erroneous billing within 30 days after discovery of the errors." The Board also found Dr. Davis "committed acts of gross negligence, in violation of Board Regulation section 317, subdivision (a), by submitting numerous erroneous bills to Highland and Superior . . . ." Contrary to

his position on appeal, Dr. Davis was disciplined for errors in his billings.

Moreover, Dr. Davis mischaracterizes the Attorney General's argument. He contends the Attorney General claims that any failure to ensure accurate billing, even if the chiropractor is unaware of the errors, constitutes "negligence." Nor did the Board find that any failure constituted negligence; it found that Dr. Davis's failure to supervise his billing staff and to understand the billing codes constituted gross negligence. Based on the 114 errors and Dr. Davis's own admission that he had nothing to do with the billing, there was ample evidence to support the finding of negligence, whether or not he had notice of the errors.

II

Excessive Treatment

Dr. Davis contends that Board Regulation section 317, subdivision (d) and section 725 of the Business and Professions Code are unconstitutionally vague and therefore void as applied to his case. Eschewing the parties' squabble over who waived the issue at what level, we review de novo as a question of law the constitutional challenge, except as to those facts upon which the application of the regulation and statute depend. We must defer to any factual findings supported by substantial evidence regarding a standard of practice for chiropractors.

Board Regulation section 317 provides, in pertinent part: "Unprofessional conduct includes, but is not limited to, the following: [¶] . . . [¶] (d) The administration of treatment

or the use of diagnostic procedures which are clearly excessive as determined by the customary practice and standards of the local community of licensees." Business and Professions Code section 725 states that "repeated acts" of clearly excessive treatment, as determined by the "standard of the community of licensees," constitutes "unprofessional conduct" for which a licensee may be disciplined.

Dr. Davis maintains that "excessive treatment" is so vague that he has to guess at its meaning and people of common intelligence differ as to its application. As a result, there is the dangerous and real possibility of arbitrary and discriminatory enforcement of the regulation and statute. (*People v. Duz-Mor Diagnostic Laboratory, Inc.* (1998) 68 Cal.App.4th 654, 670.) He urges us to find such an elusive concept as "excessive treatment" unconstitutional and, therefore, void.

It is true that "[r]ules and 'statutes must be sufficiently clear as to give a fair warning of the conduct prohibited . . . .' [Citation.] This prohibition against vagueness has been held to extend to administrative regulations affecting conditions of governmental employment. [Citation]." (*Arellanes v. Civil Service Com.* (1995) 41 Cal.App.4th 1208, 1216.)

We do not assess the vagueness challenge to the statute and regulation in the abstract but in light of the facts of the case before us. (*Cranston v. City of Richmond* (1985) 40 Cal.3d 755, 764.) Dr. Davis treated J.T. over 100 times for his sprained

ankle and over 160 times for his sore back. He contends there is no standard number of treatments or standardized protocol against which his care of J.T. can be measured. But "where the language of a statute fails to provide an objective standard by which conduct can be judged, the required specificity may nonetheless be provided by the common knowledge and understanding of members of the particular vocation or profession to which the statute applies." (*Id.* at p. 765.)

Indeed, Board Regulation section 317, subdivision (d) codifies that very principle. It states that unprofessional conduct includes treatments "which are clearly excessive as determined by the customary practice and standards of the local community of licensees." Dr. Davis insists the definition is unconstitutionally vague because the Board's expert testified the number of treatments he provided J.T. was excessive and his expert testified they were not. He concludes there is no standard when even the experts disagree. Not so. If expert witnesses had to agree in order to establish customary practice or standards, there would be few, if any, standards of practice since it is easy to retain an expert witness to express an errant view.

Here the court found the testimony of Dr. Phillip Rake to be more persuasive than the testimony of Dr. Michael Martello. Dr. Rake testified treatment is excessive, according to community standards, when it is not medically necessary. It is not sufficient for the initial treatment plan to be medically necessary; over time, a chiropractor must continue to assess a

patient at each visit to determine whether continued treatment is necessary. According to Dr. Rake, if a patient does not improve, then the course of treatment should be modified or discontinued. Based on Dr. Rake's testimony, the trial court concluded, "Patient JT's subjective belief regarding the benefits of the treatment provided do not override Dr. Rake's opinion regarding community standards and the lack of documented medical necessity in JT's medical file." This is a factual finding we are not at liberty to upset since there is substantial evidence to support it.

Dr. Davis attempts to equate "excessive treatment" with "grossly improbable statements," a vague criteria rejected by the Supreme Court in 1906. (*Hewitt v. State Board of Medical Examiners* (1906) 148 Cal. 590 (*Hewitt*).) In an era when advertising was still deemed unprofessional, the Legislature prohibited doctors from making "grossly improbable statements," but as the Supreme Court pointed out, it did not pretend to define what constitutes "grossly improbable statements." The Supreme Court explained, "[N]or is there any definite rule declared whereby after such advertisement is had the board of medical examiners shall be controlled in determining its probability or improbability. The physician is not advised what statements he may make which will not be deemed 'grossly improbable' by the board. No rule is provided whereby he can tell whether the publication he makes will bring him within the ban of the provision or not. The advertisement in connection with his medical business may be made in entirely good faith;

the statement may be of such a character that it involves no moral delinquency on the part of the physician, nor in any degree tends to deceive or injure the public. These matters, however, have no controlling effect." (*Id.* at pp. 593-594.)

Unlike in *Hewitt*, neither the challenged statute nor regulation confers on the Board unfettered discretion to make an ex post facto determination of prohibited conduct. Rather, the local community of chiropractors provides the standard. Our opinion in *Holt v. Department of Food & Agriculture* (1985) 171 Cal.App.3d 427 (*Holt*) provides a much more apt analogy.

In rejecting a pest control operator's vagueness challenge, we concluded, "[T]he statutes and regulations provide sufficiently clear standards to give fair notice of the proscribed conduct." (*Holt*, *supra*, 171 Cal.App.3d at p. 432.) In an earlier case we had rejected the same challenge to the phrases "'faulty, careless or negligent manner,' 'circumstances where injury is likely to result to plants . . . through drift,' and 'reasonable precautions . . . to confine the material applied substantially' to the intended area." (*Ibid.*, quoting *Wingfield v. Fielder* (1972) 29 Cal.App.3d 209, 216-217.) Our rejection of the challenge is equally applicable to the case now before us. We wrote: "'The operator is given sufficiently definite notice as to the proscribed conduct when measured by common understanding and practice and in the light of the potential for harm involved in the use of pesticides by aerial application.'" (*Holt*, at p. 432.) The standards were "'not at

all vague but are sufficiently definite and certain to anyone associated with crop dusting or spraying by air.'" (*Ibid*.)

Similarly, while there is no precise number of treatments prescribed for a particular injury because of, as Dr. Martello explained, the difference in patients and how they respond to treatment, "excessive treatment" is sufficiently definite and certain to the local community of chiropractors. Because Board Regulation section 317, subdivision (d) and section 725 of the Business and Professions Code both define excessive treatment by reference to the standards adhered to by the local community of chiropractors, we reject Dr. Davis's contention that "excessive treatment" is too vague to pass constitutional muster. As applied to the facts before us, Dr. Davis's ostensible legal challenge is nothing but a disguised factual challenge to the sufficiency of the evidence to support the finding that under the standard accepted by local chiropractors the treatment he provided J.T. was excessive.

Dr. Davis raises a slightly different issue he also characterizes as a legal question. He asserts that the superior court agreed with the Board's legal conclusion that treatments are excessive if given to ameliorate pain but with no curative effect. We disagree with his reading of the record. Neither the trial court nor the Board found, in derogation of former section 4600 of the Labor Code, which provides that an injured worker is entitled to treatments that "cure or relieve" the symptoms of an industrial injury, as a matter of law that any treatment to relieve pain alone was excessive. Rather the

Board, sustaining the factual findings of the ALJ, found: "After the initial course of therapy, J.T. began scheduling appointments whenever he felt he needed them. J.T. would make his appointments, arrive at respondent's facility, be treated by one of respondent's employees/chiropractic assistants with massage, ultrasound, electrical stimulation, RICE, etc. These therapies made J.T. feel better, so he continued the treatments even though there was no medical necessity for the nature and number of the continued 'treatments.' Consequently, respondent was repeatedly negligent and acted in a grossly negligent manner in his treatment of J.T. by allowing J.T. to become dependent, by providing treatments that were not medically necessary and by fostering chronicity."

Dr. Davis and Dr. Martello opined that an industrially injured worker designated "permanent and stationary" was entitled to future medical treatments at the sole discretion of the patient. It is very different to argue that a patient is entitled to treatment to ameliorate pain than it is to contend a patient is entitled to unfettered access to massage and ancillary services. As a matter of law, an injured worker may be entitled to future medical treatment to stabilize and maintain a permanent injury, but as a matter of fact, the patient may not be entitled to unlimited treatment to feel better. Because in this case the administrative tribunal as fact finder found that Dr. Davis negligently fostered J.T.'s dependency on treatments and negligently authorized his staff to provide feel-good treatments on demand, we reject Dr. Davis's

argument that he provided "excessive treatment" as a matter of law once J.T.'s condition became permanent and the treatments targeted pain relief.

In his reply brief, Dr. Davis represents that the Board expert "testified that it is not medically necessary for a chiropractor to treat pain, unless he can also cure the patient." He provides no citation to the record. Again, we read his testimony differently. Dr. Rake explained at some length how Dr. Davis failed to document or record J.T.'s subjective complaints. He testified: "Again, I did see rexams [*sic*]. Again, I have no problem with rexams [*sic*]. The problem I have is there was no information regarding the subjective complaints on the rexams [*sic*], in the SOAP notes or on the flow sheets that I could find to correlate the rexams [*sic*]. For example, out of -- I think there were 24 or 25 total examinations for these two work comp cases -- conditions. Out of the 24 or 25 rexams [*sic*], I only found two or three of the exams where the subjective finds for the patient's complaints were actually documented. So I had about 22 rexams [*sic*] being performed for what? What was the purpose? What were the patient's complaints? How were they getting better? How were they getting worse? Were they having any radiating pain? Was their work aggravating their conditions? Was their care beneficial at that point? Was there a pain scale performed? Were outcome assessment questionnaires utilized to determine scientific basis for ongoing care? The key nowadays for ongoing care would be the assessment questionnaire, which has more

validity than the doctor's physical exam finding to support ongoing care."

Thus, Dr. Rake concluded the treatment was excessive, not because a chiropractor can never provide treatment for pain relief, but because Dr. Davis failed to record J.T.'s subjective complaints. The failure to document the need for pain relief leaves open the question whether Dr. Davis ever inquired or not. We reject his contention, however, that the finding of excessive treatment was based on the wholesale legal proposition that chiropractors cannot treat injured workers to ameliorate their pain.

Finally, Dr. Davis complains the regulation is vague because it does not define a "local community," and it was unconstitutionally applied because the experts relied on chiropractic standards throughout the state. He made no attempt to prove the standard for excessive treatment varied within the state. We believe that people of common intelligence can discern the meaning of local community, and in the absence of evidence that the standard applicable to this case varied throughout California, we conclude the regulation survives constitutional scrutiny.

III

Cost Reimbursement

Dr. Davis does not challenge the penalty on appeal. He mentions the order compelling him to reimburse the Board $72,242.80 in costs at the end of his opening brief, without citation or argument, and makes no mention of these costs in

reply. As a result, any issue as to whether these costs were excessive is not before us. Indeed, this chiropractor has paid an extremely steep price for his transgressions involving a single, difficult patient who presented unique billing challenges for the welfare-to-work clerk responsible for separating charges from two industrial accidents to two different parts of the body and deciphering a complex billing code particular to the workers' compensation system. Although we may empathize with Dr. Davis, our limited role is to answer the questions of law presented, and for the reasons discussed at length above, we must answer those questions adversely to him.

DISPOSITION

The judgment is affirmed.

RAYE, J.

We concur:

NICHOLSON, Acting P. J.

ROBIE, J.